PUBLIC GOODS POOL

ANNUAL REPORT PAYOR CERTIFICATION FORM

	For the January 1 through December 31, Report Year
PAY	OR NAME ADDRESS
FED	TAX ID#
TPA	NAME TPA FED. TAX ID#
COM	IPLETED BY TELEPHONE
TITI	
payor Paym THES report	ORTANT NOTE: If an entity is 1) an insurer, 2) self-insured for its employees, and 3) serves as a TPA for other is, the entity must submit a SEPARATE report, which includes a Certification form, Report of Patient Services ents and Surcharge Obligations, Report of Covered Lives Assessments, and Payment Summary for EACH OF SE ROLES. The reports submitted for each of these roles must contain SEPARATE CERTIFICATIONS the ting submissions may NOT be combined under one certification.
Check	the appropriate box below:
[]	SELF-INSURED FUND ONLY
	This Certification and reporting submission applies to the above mentioned payor on its own behalf as a self-insured fund for its employees.
[]	OTHER THIRD-PARTY PAYORS
	This Certification and reporting submission applies to the above mentioned payor on its own behalf as an insurer.
[]	TPA: Separate Reports for Represented Organizations (Attachment 1 enclosed)
	This Certification and reporting submission applies to a third-party administrator (TPA) and its represented organizations (e.g., self-insured funds and other payors) that have been notified by the Department that they qualify for annual reporting. A separate report form is attached for each organization. <i>Attachment 1 must be completed</i> .
[]	TPA: Represented Organizations with No Public Goods Pool Liability or Independent Reporting Submission (Attachment 2 enclosed)
	This Certification and reporting submission applies to a TPA and its represented organizations that have been notified by the Department that they qualify for annual reporting; and all such organizations 1) have no Public Goods Pool liability for the reporting year or 2) are submitting the forms separately on their own behalf or 3) erroneously submitted one or more monthly reports during the current reporting year and they have no additional

patient services payments and/or New York State resident covered lives to report and no additional adjustments to patient services payments and/or covered lives information previously reported. Attachment 2 must be

completed.

[]	TPA: Represented Organizations with Separate Reports (Attachment 1 enclosed) and Represented Organizations with No Public Goods Pool Liability or Independent Reporting Submission (Attachment 2 enclosed)									
	This Certification and reporting submission applies to a TPA and its represented organizations that have been notified by the Department that they qualify for annual reporting. Some represented organizations have a Public Goods Pool liability for the reporting year (<i>Attachment 1 must be completed and a separate report must be submitted for each entity</i>) and more than one represented organization 1) has no Public Goods Pool liability for the reporting year or 2) is submitting the reporting forms separately on its own behalf or 3) erroneously submitted one or more monthly reports during the current reporting year and they have no additional patient services payments and/or New York State resident covered lives to report and no additional adjustments to patient services payments and/or covered lives information previously reported. (<i>Attachment 2 must be completed</i>).									
Also	check the appropriate box below (if applicable):									
[]	Parent Company (Attachment 1 enclosed) - This Certification and reporting submission applies to a parent company with a number of subsidiaries, and a consolidated report is attached. The parent company and all of the subsidiaries listed on Attachment 1 have been notified by the Department that they qualify for annual reporting. Attachment 1 must be completed.									
REP	ORTING REQUIREMENTS:									
This	certification and reporting submission pertains to the following:									
Chec	k all that apply:									
[]	Report of Patient Services Payments and Surcharge Obligations									
[]	Report of Covered Lives Assessment									
	CERTIFICATION									
[,	, CERTIFY THAT I AM THEOF									
ГНЕ	, AND FURTHER CERTIFY THAT THE DATA BEING PROVIDED									
HAS 1	BEEN CAREFULLY PREPARED IN ACCORDANCE WITH INSTRUCTIONS CONTAINED HEREIN,									
	UDING BUT NOT LIMITED TO THE PROPER SEGREGATION OF INFORMATION BY SERVICE									
	R, AND MAY TO SOME EXTENT BE BASED UPON INFORMATION SUBMITTED AND ATTESTED Y THE ORGANIZATIONS FOR WHICH THE REPORT IS BEING SUBMITTED. TO THE BEST OF MY									
	WLEDGE, SUCH INFORMATION ACCURATELY REFLECTS EITHER SUCH SUBMITTED									
	RMATION, OR IS ACCURATE AND CORRECT BASED ON THE BOOKS AND RECORDS WITHIN ORGANIZATION.									
SIGN	NATURE: DATE:									
PRIN	NT/TYPE NAME:									
TEL	EPHONE NUMBER:									

ATTACHMENT 1 - PAYOR CERTIFICATION (Con't) ANNUAL REPORT

TPA/Parent Company Reporting Forms - Identification of Represented Organization/Subsidiary Reporting Forms for Entities that Were Notified by the Department of Health that They Qualify for Annual Reporting

For the January 1 through December 31, ______ Report Year

TPA or Parent Co. Name:		Federal Tax ID#:																		
Contact:								Tele	epho	ne #	# :									
[]	ΓPA/ASO - submit	filing consolidated report ting on behalf of represer ting on behalf of parent c	ited 6	elect	ing	entit	ies v	with	a lia			rega	rdle	ss of	f who	ethe	ral	iabi	lity exists	i.
the entity is a parent company or a third-party adminity hom the Certification form and reporting submission is type(s) submitted by service year and payment method.	is being submitted. List	those entities you represent and	d their	r resp es (Pa	ective atient	e fede Serv	ral ta	ıx iden aymen	ntifica nt or (ation Cove	numb	er. Fo	or TPA or the	A's on curre	ly, fo	r each	enti	ty list	ted, check the	ting, for e report
			Patient Service P			* , , , , , , , , , , , , , , , , , , ,				Covered Lives Report										
Organization Name		Federal Tax ID#	1 9 9 7	1 9 9 8	1 9 9 9	2 0 0 0	2 0 0 1	2 0 0 2	2 0 0 3	2 0 0 4	1 9 9 7	1 9 9 8	1 9 9 9	2 0 0 0	2 0 0 1	2 0 0 2	2 0 0 3	2 0 0 4	Separate Check	Combined Check
																		الك		
																		\square		

ATTACHMENT 2 - PAYOR CERTIFICATION (Con't) ANNUAL REPORT

TPA Summary of Represented Electing Entities With No Public Goods Pool Liability for Represented Entities that Were Notified by the Department of Health that They Qualify for Annual Reporting

For the January 1 th	hrough December 31,	Repor	t Year									
TPA Name:	ΓPA Name: Federal Tax ID#:											
Contact:	Telephone #:											
Separately identify the represented organizations that 1) have been report for the reporting year for all HCRA service periods (i.e., continuous continuous periods) and reporting forms on their own behalf or c) en no additional patient services payments and/or New York State recovered lives information previously reported. List each entity's appropriate box under each of the categories provided below (i.e.	ommencing with the 1997 service roneously submitted one or more r esident covered lives to report and name and their federal tax identifi	period through the monthly reports du no additional adju cation number. Fo overed Lives).	current service ring the current estments to patie or each entity lis	period) or b) are reporting year an ent services payme sted, enter an "X"	submitting d they have ents and/or in the							
		Patient Servi	ce Payments	Covered Lives								
Organization Name	Federal Tax ID#	No Patient Services Surcharge Obligation	Reported Separately By Fund	No Covered Lives Assessment Obligation	Reported Separately By Fund							